Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN JACINTO METHODIST
3255 WEST PIONEER PARKWAY
ARLINGTON, TX 76013

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
#19

MFDR Tracking Number
M4-09-B138-01

MFDR Date Received
AUGUST 4, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by **SAN JACINTO METHODIST** to audit their Workers Compensation claims. We have found in this audit there is a discrepancy in regards to the appropriate reimbursement according to the Title 28 Chapter 134.404 (f) (1); Effective 3/01/08, an Inpatient admission is reimbursed by applying the IPPS Medicare pricer allowable x 143%. **Medicare would have allowed this facility $14639.76 for MS DRG 465**…T**he correct allowable is $20934.85 which is 143%-over-Medicare**. According to your payment of $15261.46 **a balance still remains**…."

Amount in Dispute: $4,626.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reimbursed $15,234.16 of a billed amount of $22.365.56. The DWC060 shows a disputed amount of $4,626.65. We feel the amount reimbursed is correct; however we will re-audit this bill to make certain our payment is correct. After the re-audit I will advise…. to attempt to resolve any differences. HRA will advise you if there is resolution…"

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2008 through August 18, 2008	Inpatient Hospital Surgical Services	$4,626.65	$4,626.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §133.4 sets out the guidelines for written notification to health care providers of

contractual agreements for informal and voluntary networks

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 08, 2009
   - 1- (45) – Charges exceed your contracted/legislated fee arrangement
   - 2- (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated July 10, 2009
   - 1- (45) – Charges exceed your contracted/legislated fee arrangement
   - 2- (W1) – Workers Compensation State Fee Schedule Adjustment
   - *-- Our position remains the same if you disagree with our decision contact the TWCC Medical Dispute Resolution (X394)
   - *-- This bill was reviewed in accordance with you Fee for Service contract with First Health. For questions regarding this analysis, please call 1-800-937-0824 (Z547)

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "1-(45) – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on November 9, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 465, and that the services were provided at San Jacinto Methodist. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $14,639.76. This amount multiplied by 143% results in a MAR of $20,934.86.

4. The division concludes that the total allowable reimbursement for the services in dispute is $20,934.86. The respondent issued payment in the amount of $15,261.46. The requestor has asked for an additional $4,626.65, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result the amount ordered is $4,626.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,626.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	April 11, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.